RPC
REPUBLICAN POLICY COMMITTEE
real ideas. real solutions.
Chairman Luke Messer

Legislative Digest

policy.house.gov | 202-226-5539

Floor Situation | Summary | Background | Cost | Staff Contact

H.R. 2570, Strengthening Medicare Advantage through Innovation and Transparency for Seniors Act of 2015, as amended

FLOOR SITUATION

On Wednesday, June 17, 2015, the House will consider H.R. 2570, Strengthening Medicare Advantage through Innovation and Transparency for Seniors Act of 2015, as amended, under suspension of the rules. The bill was introduced on May 22, 2015, by Rep. Diane Black (R-TN) and was referred to the Committee on Ways and Means, and in addition, to the Committee on Energy and Commerce.

SUMMARY

H.R. 2570 directs the Secretary of Health and Human Services to establish a three-year demonstration program to test the use of Value Based Insurance Design (VBID) methodologies in Medicare Advantage (MA) plans. VBID is an insurance methodology that reduces or eliminates co-payments for certain evidence-based medical services and prescription drugs in an effort to incentivize patients to make better health care choices, which ultimately has the potential to reduce the overall cost of care.

The bill requires the Secretary, within three years of enactment, to select at least two of the 26 Medicare Advantage regions to implement these demonstration programs.[1] Additionally, H.R. 2570 requires the Secretary to report to Congress on the progress of implementation within a year after the demonstration program begins and to contract with an independent entity to provide a report analyzing the implementation of the demonstration program, to be completed within four years of enactment.

The bill prohibits participating Medicare Advantage plans from increasing copayment or coinsurance costs "for purposes of discouraging the use" of a covered item or service. Further, the bill requires that plans selected for this program have previously received high ratings under the Centers for Medicare and Medicaid Services (CMS) Star Rating system in order to qualify to participate in the

[1] http://www.q1medicare.com/q1group/MedicareAdvantagePartD/Blog.php?blog=What-are-the-26-Medicare-Advantage-Plan-Regions-&blog_id=89&frompage=6

program. The bill also stipulates that at least 20 percent of program participants must consist of individuals who are eligible to receive certain premium and cost-sharing subsidies for low-income individuals.[2]

The bill also contains provisions allowing the Secretary to expand the duration and scope of the VBID program and to waive certain provisions of Titles XI and XVIII of the Social Security Act as necessary to carry out the demonstration program. The demonstration program is authorized to be funded by transfers from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Insurance Trust Fund, including the Medicare Prescription Drug Account. These trust funds are currently used to fund various aspects of Medicare.[3]

The bill excludes ambulatory surgical center (ASC) services from being counted toward the 50 percent meaningful use eligibility threshold until certified electronic health record (EHR) systems applicable to the ASC setting are available. The exclusion will expire three years after the Secretary of the Department on Health and Human Services has certified such EHR systems. According to the Committee, this provision resolves a burden faced by physicians practicing in ASC settings without slowing the adopting of EHR technology.

The bill sets payment amounts for Part B drugs infused through durable medical equipment (DME) items using the Average Sales Price (ASP) plus 6 percent methodology used for most physician-administered drugs. Applying this methodology to DME infused drugs would result in payment amounts that more closely relate to actual transaction prices. According to the Department of Health and Human Services, the current payment methodology for these drugs, based on manufacturer sticker prices, over pays many drugs and under pays others.[4]

The bill also provides a sense of Congress regarding the Centers for Medicare and Medicaid Services (CMS) interpretation and application of the benchmark cap as provided by the Affordable Care Act to the Medicare Advantage benchmark cap calculation. This section expresses concerns that the statute does not require the application of the benchmark cap to affect the payment of quality bonus payments, and that CMS should reflect this in its interpretation.

BACKGROUND

Value-Based Insurance Design (VBID) is an insurance methodology designed to increase health care quality and decrease costs by using financial incentives to promote cost efficient health care services and consumer choices. Health benefit plans can be designed to reduce barriers to maintaining and improving health. By covering preventive care, wellness visits and treatments such as medications to control blood pressure or diabetes at low to no cost, health plans may save money by reducing or eliminating future medical procedures.[5]

VBID adjusts patient out-of-pocket costs for prescription medications and clinical services according to the clinical value—not exclusively the cost. The current "one-size-fits-all" copayment or coinsurance design for prescription medications and clinical services provided under the Medicare program does not take into account value differences in health outcomes produced by various

[2] These low-income individuals are defined in 42 U.S.C. 1395w–114(a)(3)(A)
[3] http://www.medicare.gov/about-us/how-medicare-is-funded/medicare-funding.html
[4] See HHS Report, *"Part B Payments for Drugs Infused Through Durable Medical Equipment,"* February 2013 at 2.
[5] National Conference of State Legislators report on *"Value-Based Insurance Design,"* April 2015.

medical interventions.[6] A study of large employers who have implemented VBID methodologies into their employee health care plans have seen a small reduction in overall health care expenses, but their employees have received an improved quality of care and reduced complications from diseases.[7]

According to the bill sponsor, "There is a growing body of evidence showing individuals forgo necessary care as their out-of-pocket costs increase. This demonstration project [included within the bill] will allow high-quality plans to lower out-of-pocket costs for the care that beneficiaries need most—building upon private market initiatives already taking place in Oregon and around the country. By reducing or eliminating such costs for medically necessary drugs or services, it will be easier for seniors in MA to get evidence-based care, manage chronic conditions, and follow their treatments."[8]

COST

A cost estimate from the Congressional Budget Office (CBO) is currently unavailable.

STAFF CONTACT

For questions or further information please contact John Huston with the House Republican Policy Committee by email or at 6-5539.

[6] H.R. 2570, Section 2, Findings.
[7] See Brookings Institute, *"Health Policy Issue Brief,"* April 2014 at 11.
[8] http://black.house.gov/press-release/black-blumenauer-introduce-vbid-better-care-act-2014